CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF THE UNDERSECRETARY FOR HEALTH

Ernie Fletcher
Governor

DEPARTMENT FOR MEDICAID SERVICES
COMMISSIONER'S OFFICE
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James W. Holsinger, Jr., M.D.
Secretary

July 18, 2005

Physician #A-350
Physician Group #A-10
Rural Health Clinic #A-206
Primary Care/FQHC Center #A-357

Dear Provider:

Pursuant to requirements of 42 CFR 447.205, the Department for Medicaid Services has provided the attached Public Notice regarding amendments through 907 KAR 1:604E, Recipient Cost Sharing. Effective August 1, 2005, the Department shall establish a two (2) dollar co-payment for each physician office visit. This regulation also applies to all services provided by ARNP's, primary care centers, qualified health centers, and rural health clinics.

This co-pay will not be deducted from the provider's reimbursement. Inability or failure to pay a co-payment at the time of the service does not release an individual of the responsibility to pay a co-payment.

Federal law stipulates that some members are not required to pay co-pays. Listed below are those who **do not** have to pay a co-pay:

- Children under age 18
- Women who are pregnant or within 60 days after delivering a baby
- Members in nursing homes, personal care homes, family care homes or intermediate care facilities for people with mental retardation(ICF/MR)
- Members receiving hospice services
- Foster children
- American Indians or Alaskan Natives
- Pacific Islanders

If recipients have questions regarding this change, please have them contact the Medicaid Member Services number at 1-800-635-2570. You may contact the Physicians and Specialty Services Branch in the Division of Hospitals and Provider Operations, if you have any questions, at 502-564-2687.

Sincerely,

Shannon Turner /JM

Shannon R. Turner, J.D.
Commissioner

SRT/JM/PS/tp

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

PUBLIC NOTICE

The Cabinet for Health and Family Services, Department for Medicaid Services, pursuant to the requirements of 42 CFR 447.205, hereby gives notice of the following actions:

Prescription Drug Co-payments

Effective July 1, 2005, DMS shall establish the following co-payments on each prescription drug dispensed by a dispensing pharmacy for Medicaid and KCHIP recipients except as excluded in KRS 205.6312 and 42 CFR 447.53 and except for individuals in an optional eligibility group:

- One (1) dollar for each generic and atypical antipsychotic (if the atypical antipsychotic drug does not have a generic equivalent) dispensed by a dispensing pharmacy;
- Two (2) dollars for each brand name drug dispensed by a dispensing pharmacy if the brand name drug does not have a generic equivalent and is available under the supplemental rebate program;
- Three (3) dollars for each non-preferred brand name drug dispensed by a dispensing pharmacy

Regardless of the co-payment amount due, DMS will reduce the pharmacist's dispensing fee by one (1) dollar.

Prescription Drug Co-payments for Optional Eligibility Groups

Effective July 15, 2005, DMS shall establish the following co-payments on each prescription drug dispensed by a dispensing pharmacy for Medicaid and KCHIP recipients, except as excluded in KRS 205.6312 and 42 CFR 447.53, who are in an optional eligibility group:

- Three (3) dollar for each generic and atypical antipsychotic (if the atypical antipsychotic drug does ot have a generic equivalent) dispensed by a dispensing pharmacy;
- Ten (10) dollars for each brand name drug dispensed by a dispensing pharmacy if the brand name drug does not have a generic equivalent and is available under the supplemental rebate program;
- Twenty (20) dollars for each non-preferred brand name drug dispensed by a dispensing pharmacy

DMS will reduce the provider's reimbursement by the amount of the co-payment due.

Service Co-payments

Effective August 1, 2005, DMS shall establish the following service co-payments except as excluded in KRS 205.6312 and 42 CFR 447.53:

- Fifty (50) dollar for each inpatient hospital admission (to be deducted from provider's reimbursement)
- Three (3) dollars for each outpatient hospital service (to be deducted from provider's reimbursement)
- Three (3) dollars for each non-emergency service received via a hospital emergency room (not to be deducted from provider's reimbursement)
- Two (2) dollars for each physician office visit (not to be deducted from provider's reimbursement)

Inability or failure to pay a copayment at the time of service or prescription drug delivery does not release an individual of the responsibility to pay a co-payment. KCHIP recipients are required to pay up to a specified ceiling for their prescriptions each year.

The actions stated in this public notice are being implemented to maintain the viability of the Medicaid program. DMS anticipates that the co-payment policies will reduce expenditures by approximately $21.6 million ($15 million in federal funds and $6.6 million in state matching funds) for SFY 2006. The anticipated total savings breaks down for each category as follows: a decrease of $10 million for prescription drugs; a decrease of $5 million for emergency room visits; a decrease of $3 million for physician office visits; a decrease of $2.5 million for inpatient hospital services; and a decrease of $1.1 million for outpatient hospital services.

A copy of this notice is available for public review at the address below and each Department for Community Based Services local office. Any interested party may submit written comments regarding the proposed change within 30 days to:

Shannon Turner, J.D., Commissioner
Department for Medicaid Services
275 East Main Street
Frankfort, KY 40621